OMB Approval No. 0938-0685

MEDICARE
AND OTHER FEDERAL HEALTH CARE PROGRAM
DMEPOS SUPPLIER ENROLLMENT

Health Care Provider/Supplier Application

HCFA 855S (1/98)

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Privacy Act Statement

The Health Care Financing Administration (HCFA) is authorized to collect the information requested on this form in order to ensure that correct payments are made to providers and suppliers under the Medicare program established by Title XVIII of the Social Security Act. **See**, sections 1833(e) and 1834(j) of the Social Security Act [42 U.S.C. §§ 1395l(e) and 1395m(j)] for payment to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers under Part B of Title XVIII. In addition, HCFA is required to ensure that no payments are made to providers or suppliers who are excluded from participation in the Medicare program under section 1128 of Title XVIII [42 U.S.C. § 1320a-7] or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, (P.L. 103-355) [31 U.S.C. § 6101 note. This information must, minimally, clearly identify the provider and its' place of business as required by the Budget Reconciliation Act of 1985 (P.L. 99-272) [42 U.S.C. § 9202(g)] and provide all necessary documentation to show they are qualified to perform the services for which they are billing.

The Debt Collection Improvement Act (DCIA) of 1996 (P.L. 104-134) [31 U.S.C. §§ 3720B-3720D] requires agencies to collect the Taxpayer Identification Number (either the Social Security Number or the Employer Identification Number) from all persons or business entities doing business with the federal government. Under section 31001(i)(1) of the DCIA [31 U.S.C. § 7701(c)(1), the taxpayer identification number will be used to collect (including collection through use of offset) and report any delinquent amounts arising out of your relationship with the Government. Therefore, collection of this data element is mandatory.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in administration of the Medicare program and other Federal and State health care programs. All information on this form is required, with the exception of those sections marked as optional on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in the Federal Register in Vol. 61, no. 89, May 7, 1996), or the National Provider Identifier (NPI) System (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances, to:

(1) Contractors working for HCFA to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;

(2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;

(3) The Railroad Review Board for purposes of administering provisions of the Railroad Review or Social Security Acts;

(4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;

(5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information. (6) To the Department of Justice for investigation and prosecuting violations of the Social Security Act to which criminal penalties attach;

(7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;

(8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;

(9) Other Federal agencies who administer a Federal health care benefits program to enumerate/enroll providers of medical services or to detect fraud or abuse;

(10) State Licensing Boards for review of unethical practices or nonprofessional conduct;

(11) States for the purpose of administration of health care programs; and/or

(12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988, amended the Privacy Act, U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected on this form are protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by HCFA under 5 U.S.C. § 552(b)(4) and/or (b)(6), respectively.

MEDICARE AND OTHER FEDERAL HEALTH CARE PROGRAMS PROVIDER/SUPPLIER ENROLLMENT APPLICATION INSTRUCTIONS
DMEPOS Supplier Application - HCFA 855S

Upon completion, return this application and all necessary documentation to:

The Authorized Representative may be contacted to answer questions regarding the information furnished in this application.

General

This form is an application for enrollment in the Medicare or other federal health care programs as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Applicant must complete a separate application for each practice location where services or supplies are rendered.

For your convenience, the application form of this package has been perforated for easy removal of individual pages. It is not necessary to return the instructions or unused attachments when returning this completed application.

Claims filed for services or equipment prior to the issuance of a supplier number will not be paid.

> **Note:** To enroll in the Medicare or other federal health care programs as a provider or supplier - other than DMEPOS suppliers (i.e., physician, nurse, hospital, clinic, skilled nursing facility, etc.), applicant must complete HCFA Form 855 (General Enrollment Application).

Complete or check appropriate box in all sections of this application. Furnish all requested information in its entirety. **If any section in this application is not completed, including check boxes, this application will be returned to the applicant.**

Upon completion and approval of this application, the applicant will be issued a DMEPOS supplier billing number. This number will be automatically deactivated if it is inactive for 4 consecutive quarters. A new HCFA Form 855S must be completed and approved to re-activate the billing number.

All applicants must sign and date the Standards Certification Statement and the Certification Statement.

Definitions for terms used in this application:

Authorized Representative: The appointed official (e.g., officer, chief executive officer, general partner, etc.) who has the authority to enroll the entity in Medicare or other federal health care programs as well as to make changes and/or updates to the applicant's status, and to commit the corporation to Medicare or other federal health care program laws and regulations.

Chain Organization: Multiple DMEPOS suppliers (chains) are owned, leased or through any other devices, controlled by a single business entity. The chain organization must consist of two or more health care facilities. The controlling business entity is called the chain "Home Office." Each entity in the chain may have a different owner (generally chains are not owned by the Home Office).

Typically, the chain home office maintains uniform procedures in each facility for handling customer service, quality control, pricing, and advertising.

Examples of provider types that would typically be chain organizations are: Certified Outpatient Rehabilitation Facilities (CORFs); Skilled Nursing Facilities (SNFs); and Pharmacies.

Each location of a chain organization must submit a separate application.

Contractor/Vendor: Any individual, entity, facility, organization, business, group practice, etc., receiving an Internal Revenue Service (IRS) Form 1099 for services provided to this applicant (e.g., independent contractor, subcontractor, equipment supply manufacturer).

DMEPOS Supplier: This is a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Examples of durable medical equipment, prosthetics, and supplies are wheelchairs, pharmaceuticals, oxygen, parenteral and enteral nutrition.

Group Member: A DMEPOS supplier who furnishes services in a group practice and who reassigns benefits to the group.

Legal Business Name: The legal name of the individual or entity applying for enrollment. This name should be the same name the individual or entity uses in reporting to the IRS.

Medicaid Number: This number uniquely identifies the applicant as a Medicaid provider/supplier in a given State.

Medicare Identification Number: This number uniquely identifies the applicant as a Medicare provider/supplier and/or DMEPOS supplier and is the number used on claim forms. The Medicare Identification Number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPIN and the NSC number.

Definitions for terms used in this application: (continued)

If the applicant is enrolling in the Medicare or other federal health care programs for the first time, the applicant will receive a Medicare or other federal health care identification number upon enrollment.

National Provider Identifier (NPI): This number is assigned by the National Provider System to identify health care providers or suppliers. It will replace the Medicare Identification Number.

National Supplier Clearinghouse Number (NSC): This number uniquely identifies the applicant as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS supplier). It is the number used by DMEPOS suppliers on claim forms.

Pharmacy: A DMEPOS supplier that dispenses drugs related to durable medical equipment, prosthetics, orthotics, or supplies.

The DMEPOS supplier must be licensed as a pharmacy in the State in which it operates.

Reassignee: An individual or organization that allows another organization to bill Medicare or other federal health care programs on their behalf for services rendered.

Unique Physician Identification Number (UPIN): Number assigned to physicians, non-physician practitioners, and groups to identify the provider or supplier on Medicare claim forms.

APPLICATION COMPLETION INSTRUCTIONS

Complete or check appropriate box in all sections of this application. Furnish all requested information in its entirety. **If any section in this application is not completed, including check boxes, this application will be returned to the applicant.**

Check Type of Business: (for administrative purposes only)

Check appropriate box indicating how applicant's business is structured. The answer to this item will not affect the amount of Medicare or other federal health care program reimbursement or enrollment status.

> **Note:** If applicant's business structure is a **partnership,** applicant must provide a copy of its partnership agreement signed by all parties and identifying the general partner (if any) and a statement attesting that the partnership meets all State requirements.

Check "Applicant Enrolling As" Type: (for administrative purposes only) The answer to this item will not affect the amount of Medicare or other federal health care program reimbursement or enrollment status.

Individual: An individual person enrolling as a DMEPOS supplier.

> **Note:** An individual who is registered as a business is considered a sole proprietor for the purpose of this application and should not check this box.

Sole Proprietor: An individual person registered as a business and issued a tax identification number from the IRS and rendering services under the business name as a DMEPOS supplier.

Organization: A company, not-for-profit entity, government agency (Federal, State, or Local) or a qualified health care delivery system which renders medical care (e.g., pharmacy, equipment manufacturer, hospital, skilled nursing facility, etc.).

Group: Two or more individual practitioners or other health care providers or suppliers who form a practice together (as authorized by State law) and bill the Medicare or other federal health care program as a single unit. A group has individual practitioners.

The individual members must be enumerated and enrolled in the Medicare or other federal health care programs as individuals in order to enroll as members of the group.

Only those health care practitioners who are authorized to bill Medicare or other federal health care programs directly in their individual capacities are allowed to form a group. A group can only be enrolled if it can meet the conditions for reassignment (see instructions for Reassignment of Benefits section).

The above definition of a group is to be used for Medicare or other federal health care programs' enrollment purposes only. It is not the group definition described in Section 1877(h) of the Social Security Act.

All group member/partners must complete HCFA Form 855R.

> **Note:** **Partnerships:** for purposes of this applications, partnerships should check that they are "enrolling as" a group.

Check Appropriate Federal Health Care Program:

If applicant is enrolling in a federal health care program other than Medicare, check the appropriate box. Check only one box. For each federal health care program the applicant wishes to enroll in, the applicant must complete a separate enrollment application and submit it to that federal health care program.

Check Application For:

New DMEPOS Supplier: Applicant is not currently enrolled to bill a Medicare Durable Medical Equipment Regional Carrier (DMERC) or other federal health care program.

Enrollment of Additional Location(s): Currently enrolled DMEPOS supplier is applying to enroll a new practice location.

Check Application For: (continued)

Re-enrollment: Currently enrolled Medicare DMEPOS supplier is completing this application to satisfy periodic Medicare re-enrollment requirements.

Change of Information: Currently enrolled DMEPOS supplier is completing applicable sections to report a change in information other than a change of ownership or owner (CHOW). Currently enrolled DMEPOS suppliers may use HCFA Form 855C (Change of Enrollment Information) to report changes in name, mailing address, "Pay To" address, billing agency address, practice location address, specialty, deactivation of Medicare or other federal health care program billing number(s), addition or deletion of an Authorized Representative, surety bond changes or renewals, and potential termination of current ownership. Any change not listed above must be reported on this application, HCFA Form 855S (DMEPOS Supplier Enrollment Application).

When using this form to notify the Medicare or other federal health care program that a practice location(s), owner(s), or various personnel are no longer associated with this entity, check the appropriate deletion box in the applicable sections.

All changes must be reported in writing and have an original signature. For individuals, the DMEPOS supplier must sign, and for organizations and group practices, an "authorized representative" must sign to confirm the requested change. Faxed or photocopied signatures will **not** be accepted.

Change of Owner: The removal or addition of an owner that does not result in a change of ownership (CHOW) as defined under Change of Ownership.

> **Note:** When a change of owner is being reported, supplier must complete Supplier Identification section and Individual or Entity Ownership Information sections.

Change of Ownership (CHOW): This term applies to certain limited circumstances as defined in 42 CFR § 489.18 as described below.

A new or prospective new owner must complete this application to report new or prospective new ownership. In addition, the applicant must also submit a Reassignment of Benefits Application (HCFA Form 855R) identifying all individuals who will reassign their benefits to the applicant.

A change of ownership is defined as:

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law;
- In the case of an unincorporated sole proprietorship, transfer of title and property to another party;
- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership); and
- In the case of leasing, the lease of all or part of a DMEPOS supplier facility constitutes a change of ownership of the leased portion.

Billing Region Identification:

Supplier numbers can be used nationally when filing claims, however, check the appropriate box for region where applicant will be submitting the majority of claims (see list below).

Region A - Delaware, Connecticut, Maine, Massachusetts, NewHampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

Region B - District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, West Virginia, Wisconsin, Virginia

Region C - Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands

Region D - Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

Other Federal Health Care Program Enrollment:

If applicant is currently enrolled in any other federal health care program(s), check all appropriate boxes.

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1. Supplier Identification

If an individual or sole proprietorship, complete applicant's full name (this is the name in which payment will be made), date and place of birth, county and/or city. If applicant has previously practiced or operated a business under another name, including applicant's maiden name, supply that name under Other Name.

For Legal Business Name, supply the name the applicant uses to report to the IRS.

All applicants **must** supply either their social security number or employer identification number.

If applicant is currently enrolled in Medicare as a different provider/supplier type, furnish the Medicare Identification Number.

1. Supplier Identification (continued)

Applicant must answer all questions related to criminal activity. Answering "yes" to any of these questions will not automatically deny enrollment into the Medicare or other federal health care program. For purposes of these questions related to criminal activity, an applicant's "immediate family member" is defined as:

- a husband or wife;
- the natural or adoptive parent, child or sibling;
- the stepparent, stepchild, stepbrother or stepsister;
- the father, mother, daughter, son, brother or sister;
- parent-in-law, sister-in-law or brother-in-law;
- the grandparent or grandchild; and
- the spouse of a grandparent or grandchild.

For purposes of these questions related to criminal activity, "member of household" with respect to the applicant, is defined as
any individual sharing a common abode as part of a single family unit with the applicant, including domestic employees and others who live together as a family unit, but not a roomer or boarder.

Supply all requested information. If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If applicant has not had any adverse legal actions, check the "none of these" box.

Indicate whether the applicant (under the name of the applicant shown on this application or any other name) has any outstanding overpayments with Medicare, Medicaid, or any other federal program.

If the applicant has an outstanding overpayment, furnish the name of the federal program where the overpayment exists. If the outstanding overpayment is in a name other than the name identified in the Supplier Identification section, furnish the other name in the space provided.

2. Type of Business

Provide type of business. Check only one item in this section.

Sole Proprietorship - An individual who is registered as a business and issued a tax identification number from the IRS, and who will bill Medicare under the business name.

Business Corporation - A commercial enterprise or establishment comprised of many employees and legally recognized as a separate entity.

General Partnership - A contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in a proportion of profits and losses.

Joint Venture - A business that is co-owned by another individual, organization or business.

Professional Corporation - A commercial enterprise or establishment engaged in a specific activity or area of expertise comprised of one or more employees who are educated in the specific activity or area of expertise and legally recognized as a separate entity.

3. Practice Location

Complete all information requested. For each practice location the applicant wishes to enroll in the Medicare or other federal health care program, a separate application must be submitted.

Post Office boxes and drop boxes are **not** acceptable as a practice location address. The telephone number must be a number where customers can call to ask questions or register complaints.

Furnish the "Doing Business" name the applicant uses for this practice location.

Supply the name and social security number of the head managing/directing employee for this practice location.

Supply "Pay To" address if applicant's payments are going to an address other than the address reported in Section 3A. The "Pay To" address may be a Post Office box or drop box. Payments will be made in the individual or Legal Business name as reported in the Supplier Identification section.

Indicate whether patient records are kept on the premises. If records are not kept at the practice location, supply the name of the storage facility/location and the physical address where the records are maintained. Post Office Boxes and drop boxes are **not** acceptable as the physical address where patient records are maintained.

4. Prior Practice Information

FOR MEDICARE ENROLLMENT ONLY

If applicant has previously billed Medicare or Medicaid, supply requested information on prior practice(s). Check if applicant was a participating or non-participating provider or supplier in the prior practice(s).

5. Mailing Address

Complete applicant's mailing address. This is where the applicant can receive correspondence from the Medicare or other federal health care program contractors. This address may be the applicant's home address, Post Office box, or a drop box.

6. Incorporation/Establishment

Supply information about applicant's incorporation/establishment status as requested.

7. Nature of Business

Provide nature of applicant's business. Check all items that apply. Indicate applicant's primary and secondary nature of business.

8. Type of Supplier

Check all applicable items. Indicate applicant's primary and secondary DMEPOS supplier types.

9. Professional and Business License, Certification, and Registration Information

All applicants are required to furnish information on all Federal, State and Local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in applicant's State (e.g. Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license, etc.). The local Medicare or other federal health care contractor will supply specific licensing requirements for a DMEPOS supplier upon request.

Notarized or "certified true" copies of the above information are optional, but will speed the processing of this application.

> **Notarized:** A notarized copy of an original document that will have a stamp which states "Official Seal" along with the name of the notary public, State, County, and the date the notary's commission expires.
>
> **Certified True:** This is a copy of the original document obtained from where it originated or is stored, and it has a raised seal which identifies the State and County in which it originated or is stored.

In lieu of copies of the above requested documents, the applicant may submit a notarized Certificate of Good Standing from the applicant's State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

> **Note:** Temporary licenses are acceptable submissions with this application. However, once received, a copy of the applicant's permanent license must be forwarded to the Medicare or other federal health care contractor within 30 days of receipt.

If applicant has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application if applicable.

10. Proof of Liability Insurance

All DMEPOS suppliers enrolling in Medicare, and when required, in other federal health care programs, must have liability insurance. Supply the requested information and submit a copy(s) of applicant's current liability insurance policy with this application.

11. Individual Ownership Information

> **Note:** Applicants enrolling as individuals or sole proprietors are considered owners and **must** complete all requested information in this section.

Complete this section for all individuals who have an ownership or control interest in the applicant's business. If applicant is owned by another entity, complete the Entity Ownership Information section.

A person or entity with an ownership or control interest is one that:

- has an ownership interest totaling 5 percent or more in the DMEPOS supplier;
- has a direct, indirect, or combination of direct and indirect ownership interest equal to 5 percent or more in the DMEPOS supplier, where the amount of an indirect ownership interest is determined by multiplying the percentages of ownership in each entity (for example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the DMEPOS supplier, A's interest equates to an 8 percent indirect ownership interest in the DMEPOS supplier and must be reported);
- owns an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the DMEPOS supplier if that interest equals at least 5 percent of the value of the property or assets of the DMEPOS supplier;
- is an officer or director of a DMEPOS supplier that is organized as a corporation; and/or
- is a partner in a DMEPOS supplier that is organized as a partnership.

Complete owner's full name and social security number. If owner has previously practiced or operated a business under another name, including maiden name, supply it under Other Name.

Supply all requested information about the owner's past and present billing relationships with Medicare.

Supply all requested information about other entities the owner managed or directed that billed Medicare.
Supply all requested information about other entities the owner owned or had controlling interest in that billed Medicare.

Supply all requested adverse legal action information about the owner(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the owner(s) has had any adverse legal actions, check the "none of these" box.

11. Individual Ownership Information (continued)

Applicant must answer all questions related to criminal activity. Answering "yes" to any of these questions will not automatically deny enrollment into the Medicare or other federal health care programs.

Attach a copy of the entity's IRS Form CP 575 pertaining to this DMEPOS supplier. The IRS Form CP 575 will be used to verify the employer identification number. In lieu of the IRS Form CP 575, the applicant may use any official correspondence from the IRS showing the name of the entity as shown on this application and the tax identification number.

12. Entity Ownership Information

Complete this section for all entities who have an ownership or control interest in the applicant's business.

For definition of ownership or control interests, see instructions in the Individual Ownership Information section.

Entities with ownership interest must provide their legal business name(s).

Supply all requested information about the entity's past and present billing relationships with Medicare.

Supply all requested information about other entities this entity managed or directed that billed Medicare.

Supply all requested information about other entities this entity owned or had controlling interest in that billed Medicare.

Supply all requested adverse legal action information about the entity(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the entity(s) has had any adverse legal actions, check the "none of these" box.

Indicate whether this entity is controlled by a Board of Directors. If yes, furnish the full name and social security number of each Board member.

> **Note:** Non-profit organizations should list the Board of Directors and Managing/Directing Employees in this section. All non-profit organizations must also submit a copy of their non-profit approval notification from the IRS (501(c)(3)).

Attach a copy of the entity's IRS Form CP 575 pertaining to this DMEPOS supplier. The IRS Form CP 575 will be used to verify the employer identification number. In lieu of the IRS Form CP 575, the applicant may use any official correspondence from the IRS showing the name of the entity as shown on this application and the tax identification number.

13. Managing/Directing Employees

> **Note:** This section **is not** to be completed with information referring to billing agency or management service organization employees.

Applicant may skip this section only if all three of the statements listed below are true:

1. This DMEPOS supplier is owned by the individual owner who is listed in the Individual Ownership Information section;

2. The owner listed in the Individual Ownership Information section is the sole owner of this entity; **AND**

3. The owner listed in the Individual Ownership Information section is also the sole managing/directing employee of this entity.

Complete this section for all the managing/directing employees, including, but not limited to, general manager(s), business manager(s), administrator(s), director(s), or other individuals who exercise operational or managerial control over the DMEPOS supplier, or who directly or indirectly conduct the day-to-day operations of the DMEPOS supplier.

> **Note:** For large entities, furnish only the top 20 compensated managing/directing employees. Social security numbers **must** be provided for all persons listed in this section.

All organizations should include the corporate officers as well as the managing/directing employees in this section.

Supply all requested information about the managing/directing employee's past and present billing relationships with Medicare or other federal health care programs.

Supply all requested information about other entities this managing/directing employee managed or directed that previously billed or are presently billing the Medicare or other federal health care programs.

Supply all requested information about other entities this managing/directing employee had ownership interest in that previously billed or are presently billing the Medicare or other federal health care programs.

Supply all requested adverse legal information about the managing/directing employee(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the managing/directing employee(s) has had any adverse legal actions, check the "none of these" box.

14. Parent/Joint Venture Information

If applicant is a subsidiary (wholly owned by another organization or business) or a joint venture (co-owned by another individual(s), organization(s), or business(s)), complete all information requested in this section about the parent company or joint venture. Attach a copy of parent company's or other owner's IRS CP 575 Form pertaining to this DMEPOS supplier.

15. Chain Organization Information

If applicant is a chain organization (e.g., pharmacies, medical equipment suppliers, etc.), check appropriate action block for this chain, then supply all information requested about the chain home office.

16. Contractor/Vendor Information (Business Organizations)

This section is to be completed with information about all business organizations that the applicant contracts with that:

- provide medical or diagnostic services or medical supplies for which the cost or value is $10,000 or more in a 12 month period; OR
- will reassign benefits to the applicant, regardless of annual cost or value of medical or diagnostic services or medical supplies provided.

Provide all requested information about the contractor/vendor's past and present billing relationships with Medicare or Medicaid.

Supply all requested adverse legal action information about the contractor/vendor(s). If applicable, attach copy(s) of any official documentation related to the adverse legal action identified, including reinstatement notices. If none of the contractor/vendor(s) has had any adverse legal actions, check the "none of these" box.

If a business or group contractor/vendor will be reassigning Medicare or other federal health care program benefits to the applicant, an authorized representative of the business or group contractor/vendor must complete and sign the Reassignment of Benefits section of this application. See instructions below for additional reassignment of benefits information.

> **Note:** Individuals with whom the applicant contracts with to do business and who will reassign benefits to the applicant must complete the **HCFA Form 855R** (Individual Reassignment of Benefits Application).

If a currently enrolled DMEPOS supplier is obtaining the services of a new contractor/vendor that will be reassigning its benefits, complete only the Supplier Identification section, the Contractor/Vendor Information section and the Reassignment of Benefits Statement.

17. Reassignment of Benefits Statement

In general, Medicare and other federal health care programs make payment only to the beneficiary or the individual or entity that directly provides the service.

Reassigned benefits must be within the same federal health care program (e.g., Medicare to Medicare, CHAMPUS to CHAMPUS, etc.).

If the applicant receives payment on behalf of other business organizations for services provided, the other business organization must complete and sign the Reassignment of Benefits Statement. Failure to do so will cause a delay in processing the application and limit the Medicare or other federal health care program contractor's ability to make payment.

This section must be signed by an authorized representative of the entity reassigning its benefits to this applicant.

The resignee is permitted by Federal law to reassign Medicare benefits to an employer, the facility where the service is rendered, a health care delivery system, or agent. For further information on Federal requirements on reassignment of benefits the applicant should contact the local Medicare or other federal health care contractor before signing the application.

The Legal Business Name of the applicant must be the same as the Legal Business Name of the applicant identified in Section 1 of this application.

Individual practitioners, including individual contractor/vendors and group members, who reassign Medicare or other federal health care program benefits to this applicant must complete the HCFA Form 855R. Individual practitioners who are contracted by the applicant, but do not reassign their benefits to the applicant do not need to complete the HCFA Form 855R.

18. Pharmacist-In-Charge

If applicant is a pharmacy, complete all requested information about the Pharmacist-In-Charge, including social security number.

> **Note:** Pharmacist-In-Charge must sign the Standards Certification Statement section and the Certification Statement section of this application.

19. Billing Agency/Management Service Organization Address

A Billing Agency is a company contracted by the applicant to furnish all claims processing functions for the applicant's practice.

19. Billing Agency/Management Service Organization Address (continued)

A Management Service Organization is a company contracted by the DMEPOS supplier to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.

If the applicant currently uses or will be using a billing agency or management service organization to submit bills, complete all requested information and attach a current copy of the signed contract between the applicant and the company.

Note: If applicant has a relationship with a billing agency or management service organization but no written agreement or contract exists between the applicant and the company, than an agreement or contract must be written and furnished with this application.

Note: Any change in the contract or agreement between the applicant and the billing agency or management service organization must be reported to the Medicare or other federal health care program contractor within 30 calendar days.

20. Surety Bond Information

Complete all requested information.

Annual surety bond renewals must be reported to the Medicare or other federal health care program contractor using HCFA Form 855C (Change of Enrollment Information).

An original copy of the surety bond must be submitted with this application. Failure to submit a copy of the surety bond will prevent the processing of this application. In addition, the surety bond company must submit a certified copy of the agent's Power of Attorney with this application, if the bond is issued by an agent.

21. Standards Certification Statement

MEDICARE APPLICANTS ONLY

This statement includes the minimum standards to which the applicant must adhere to be enrolled in the Medicare program as a DMEPOS supplier. Read these statements carefully.

By signing the Standards Certification Statement, applicant agrees that he/she has read and understood the statement, and that the supplier meets, and will continue to meet all the supplier standards listed in 42 CFR § 424.57 (as they currently exist and any future amendments to said standards) and may be denied entry to the program if any standards are not met or revoked if these standards are violated.

A list of the current supplier standards as found in 42 CFR § 424.57 is included as a separate document in this application package. Additional copies can also be obtained by contacting the National Supplier Clearinghouse at (803) 754-3951.

Note: If applicant is applying as an individual or sole proprietor, **applicant** must sign and date the Standards Certification Statement. If applicant is applying as an organization or group practice, **an authorized representative** must sign the statement. If applicant dispenses drugs related to DMEPOS or is licensed as a pharmacy, the **Pharmacist-In-Charge** must also sign this statement.

22. Certification Statement

This statement includes the minimum standards to which the applicant must adhere to be enrolled in the Medicare or other federal health care program.

Read these statements carefully.

By signing the Certification Statement, applicant agrees to adhere to all the conditions listed and is aware that the supplier may be denied entry to or revoked from the program if any conditions are violated. The Certification Statement must contain an original signature. Faxed or photocopied signatures will not be accepted.

Note: If applicant is applying as an individual or sole proprietor, **applicant** must sign and date the Certification Statement. If applicant is applying as an organization or as a group practice, **an authorized representative of the organization or group practice** must sign the Certification Statement. If the applicant has more than one authorized representative, furnish the names and signatures of those authorized representatives who will be directly involved with the Medicare or other federal health care contractor. If applicant dispenses drugs related to DMEPOS or is licensed as a pharmacy, the **Pharmacist-In-Charge** must also sign this statement.

Note: Any changes to the information furnished in this application must be reported to the National Supplier Clearinghouse, P.O. Box 100142, Columbia, South Carolina, 29202-3142, within 30 days of change.

OMB Approval No. 0938-0685

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Application

PLEASE CHECK APPLICABLE BOX

Type of Business: ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (specify) _____

PLEASE CHECK APPLICABLE BOX

Applicant Enrolling As: ☐ Individual ☐ Sole Proprietor ☐ Organization ☐ Group

Check the appropriate federal program listed below if applicant is completing this application for enrollment in a federal program other than Medicare.
(Check only one program box.)

☐ State Medicaid ☐ CHAMPUS ☐ Indian Health Service
☐ Public Health Service ☐ CHAMPVA ☐ Railroad Retirement Board
☐ Other (specify) _____

PLEASE CHECK APPLICABLE BOX(ES)

Application For: ☐ New DMEPOS Supplier ☐ Enrollment of Additional Location(s) ☐ Re-enrollment
☐ Change of Information ☐ Change of Owner ☐ Change of Ownership

Which region will applicant be submitting the majority of billings?

☐ Region A ☐ Region B ☐ Region C ☐ Region D

Is the applicant currently enrolled in another federal health care program? ☐ **YES** ☐ **NO**

IF YES, check the appropriate federal program(s) listed below.

☐ Medicare ☐ State Medicaid ☐ CHAMPUS ☐ Indian Health Service
☐ Railroad Retirement Board ☐ Public Health Service ☐ CHAMPVA ☐ Other (specify) _____

1. Supplier Identification

A. Identifying Information

Individual Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Legal Name of Business

Social Security Number	Employer Identification Number	Medicare Identification Number (if applicable)

Gender (optional) ☐ male ☐ female

Race/Ethnicity (optional) ☐ Asian or Asian American or Pacific Islander ☐ Hispanic ☐ Black (not Hispanic) or African-American ☐ North American Indian or Alaska Native ☐ White (not Hispanic)

Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth

B. Has applicant ever been convicted of any health care related crime? ☐ **Yes** ☐ **No**
Has applicant ever been convicted of a felony under Federal or State law? ☐ **Yes** ☐ **No**

C. Has any family and/or household member(s) of the applicant who has ownership or control interest in the enrolling business or entity ever been convicted, assessed, or excluded from the Medicare program due to fraud, obstruction of an investigation, or a controlled substance violation?

☐ **Yes** ☐ **No** **IF YES, furnish information below. For additional names, copy and complete Section 1C.**

Name:	First	Middle	Last	Jr., Sr., etc.	Relationship
Name:	First	Middle	Last	Jr., Sr., etc.	Relationship

D. Check if the applicant has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed.
Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
☐ Administrative Sanction(s) _____
☐ Program exclusion(s) _____
☐ Suspension of payment(s) _____
☐ Civil monetary penalty(s) _____
☐ Assessment(s) _____
☐ Program Debarment(s) _____

2. Health Care Related:
☐ Criminal fine(s) _____
☐ Restitution order(s) _____
☐ Pending civil judgment(s) _____
☐ Pending criminal judgment(s) _____
☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does the applicant have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

E. Does the applicant, under any name or business identity, have any outstanding overpayments with Medicare, Medicaid or any other federal program?

☐ **Yes** ☐ **No** **IF YES, under what federal program?** _____
IF YES, under what name? _____

2. Type of Business (Check applicable box)

☐	Sole Proprietorship	☐	General Partnership	☐	Professional Corporation	☐	Other (specify)
☐	Business Corporation	☐	Joint Venture	☐	Limited Liability Corporation		_____

3. Practice Location

Check here ☐ **if deleting this practice location.**

A. Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4

Telephone Number	Fax Number	E-mail Address	Date Business Established at this location
( )	( )		(MM/DD/YYYY)

B. Under what name does applicant conduct business at this practice location?

C. Is this address a residence? ☐ Yes ☐ No

Is this practice location open to the public? ☐ Yes ☐ No

Does this applicant own or lease this practice location? ☐ Own ☐ Lease

D. Name of managing/directing employee for this practice location? First	Middle	Last	Social Security Number

E. "Pay To" Address for this practice location. If same as practice location in Section 3A, check here ☐ and skip to Section 3F.

Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4	Telephone Number
			( )

F. Are all patient records stored at this practice location? ☐ **Yes** ☐ **No IF NO, supply storage location below.**

Name of Storage Facility/Location

Street Address Line 1

Street Address Line 2

City	State	ZIP Code + 4

Telephone Number	Fax Number	E-mail Address
( )	( )	

4. Prior Practice Information

Check here ☐ **only if this entire section does not apply to the applicant.**

If applicant has previously billed the Medicare or Medicaid programs furnish requested prior practice information below.
For each prior practice, copy and complete this section.

Type of Prior Practice	Date Prior Practice Terminated (MM/DD/YYYY)

Prior Legal Business Name

Prior Doing Business As Name

Prior Medicare Identification Number	Prior Medicaid Identification Number/State	Prior Tax Identification Number (EIN/SSN)

Prior Business Street Address Line 1

Prior Business Street Address Line 2

Prior City	Prior State	Prior ZIP Code + 4

Was applicant a ☐ participating or ☐ non-participating provider/supplier in this prior practice?

5. Mailing Address

If mailing address is the same as the practice location address listed in Section 3A of this application, check here ☐ and skip to the next section.

Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address

6. Incorporation/Establishment

Check here ☐ only if this entire section does not apply to the applicant.

Incorporation Date (MM/DD/YYYY)	Incorporation State	Date Business Established in This State (MM/DD/YYYY)

7. Nature of Business

Please check all that apply.

- ☐ Durable Medical Equipment
- ☐ Parenteral and Enteral Nutrition
- ☐ Drugs/Pharmaceuticals
- ☐ Dialysis Equipment and Supplies (attach copy of dialysis clinic contract)
- ☐ Supplies for Nursing Facilities
- ☐ Customized Items
- ☐ Orthotics
- ☐ Prosthetics
- ☐ Optician
- ☐ Oxygen

Which of the above is applicant's primary nature of business? _____

Which of the above is applicant's secondary nature of business? _____

8. Type Of Supplier

Please check all that apply.

- ☐ Medical Supply Company
- ☐ Medical Supply Company with Registered Pharmacist
- ☐ Medical Supply Company with Respiratory Therapist
- ☐ Medical Supply Company with Orthotic Personnel
- ☐ Medical Supply Company with Prosthetic Personnel
- ☐ Medical Supply Company with Orthotic-Prosthetic Personnel
- ☐ Physician (specify specialty) _____
- ☐ Pharmacy
- ☐ Department Store
- ☐ Grocery Store
- ☐ Optometrist
- ☐ Optician
- ☐ Hospital
- ☐ Nursing Facility
  - ☐ Skilled Care
  - ☐ Intermediate Care
  - ☐ Other
- ☐ Home Health Agency
- ☐ Orthotic Personnel
- ☐ Prosthetic Personnel

Which of the above is applicant's primary type of supplier? _____

Which of the above is applicant's secondary type of supplier? _____

9. Professional and Business License/Certification/Registration Information

Attach a copy of each required Federal, State, and/or local county/city business and/or professional license, certification or registration. Notarized or "certified true" copies are optional but will speed the processing of this application.

Has applicant ever had any Federal, State, and/or local county/city business and/or professional business license, certification or registration revoked or suspended? ☐ Yes ☐ No

IF YES, explain below and attach copy of reinstatement letter, if applicable.

_____

_____

10. Proof of Liability Insurance

Applicant must attach copy of their liability insurance policy to this application.

Name of Insurance Company

Insurance Policy Number	Date Policy Issued (MM/DD/YYYY)		Expiration Date of Policy (MM/DD/YYYY)
Insurance Agent's Name: First	Middle	Last	Jr., Sr., etc.
Telephone Number ( )	Fax Number ( )		E-Mail Address

11. Individual Ownership Information

Check here ☐ only if this entire section does not apply to the applicant.

Check here ☐ if deleting this owner's association with this entity. Effective date of deletion? _____ (MM/DD/YYYY)

How many owners have 5 percent or more ownership interest in this entity? _____ (maximum of 20)

For each owner, copy this page and complete this section. Applicants must submit a copy of the entity's IRS Form CP 575.

A. Identifying Information

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Employer Identification Number	Medicare Identification Number

B. Does this owner now have or has this owner ever had a Medicare or Medicaid provider number in this or any other State?

☐ Yes ☐ No IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

C. Has this owner ever managed or directed other organizations that have billed or are currently billing Medicare for services?

☐ Yes ☐ No IF YES, how many? _____ Copy and complete the following for each organization:

Organization's Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

D. Has this owner ever had ownership in other organizations that have billed or are currently billing Medicare for services?

☐ Yes ☐ No IF YES, how many? _____ Copy and complete the following for each organization:

Organization's Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Check if this owner has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed.
Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this owner have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

F. Has this owner ever been convicted of any health care related crime? ☐ Yes ☐ No

Has this owner ever been convicted of a felony under Federal or State law? ☐ Yes ☐ No

12. Entity Ownership Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Check here ☐ **if deleting this owner's association with this entity. Effective date of deletion?** _____ **(MM/DD/YYYY)**

How many entities have 5 percent or more ownership interest in this DMEPOS supplier? _____ **(maximum of 20)**

For each entity with an ownership interest in this DMEPOS supplier, copy this page and complete this section.

Applicants must submit a copy of the entity's IRS Form CP 575.

A. Identifying Information

Legal Business Name:

"Doing Business As" Name:

Effective Date of Ownership (MM/DD/YYYY)	Employer Identification Number	Medicare Identification Number

B. Does this entity owner now have or ever had a Medicare or Medicaid provider number in this or any other State?

☐ **Yes** ☐ **No** **IF YES, supply all current and prior information requested below.**

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

C. Has this entity ever managed or directed other organizations that have billed or are billing Medicare for services?

☐ **Yes** ☐ **No** **IF YES, how many?** _____ **Complete the following for each organization:**

Organization's Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

D. Has this entity ever had ownership in other organizations that have billed or are billing Medicare for services?

☐ **Yes** ☐ **No** **IF YES, how many?** _____ **Complete the following for each organization:**

Organization's Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Check if this entity has <u>ever</u> had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed.
Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this entity have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

F. Does this entity have a Board of Directors? ☐ **YES** ☐ **NO** **IF YES, submit a list of the top 20 Directors.**

This list must include Board member's full name and social security number. (If additional space is needed, copy and complete this section.)

Board Member Name: First	Middle	Last	Jr., Sr., etc.	Social Security Number
Board Member Name: First	Middle	Last	Jr., Sr., etc.	Social Security Number
Board Member Name: First	Middle	Last	Jr., Sr., etc.	Social Security Number
Board Member Name: First	Middle	Last	Jr., Sr., etc.	Social Security Number

13. Managing/Directing Employees

Check here ☐ **if this DMEPOS supplier is owned by the individual owner who is listed in Section 11, AND**
☐ **the owner listed in Section 11 is the sole owner, AND**
☐ **the owner listed in Section 11 is also the sole managing/directing employee of this entity.**

If all 3 boxes above are checked, skip this section.

Check here ☐ **if deleting this Managing/Directing employee's association with this entity.**
Effective date of deletion? _____ **(MM/DD/YYYY)**

For each additional managing/directing employee of this location, copy and complete this section.

A. Identifying Information

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Employer Identification Number (if applicable)	Medicare Identification Number (if applicable)

Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth

Legal Name of Business Where This Employee Manages/Directs

"Doing Business As" Name Where This Employee Manages/Directs

B. Has this managing/directing employee ever had a Medicare or Medicaid provider number in this or any other State?
☐ **Yes** ☐ **No** **IF YES, supply all current and prior information requested below.**
If additional space is needed, copy and complete this section.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

C. Has this managing/directing employee ever managed or directed other organizations that have billed or are billing Medicare for services? ☐ **Yes** ☐ **No** **IF YES, how many?** _____ **Complete below for each organization.**
If additional space is needed, copy and complete this section.

Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

D. Has this managing/directing employee ever had an ownership interest in other organizations that have billed or are billing Medicare for services? ☐ **Yes** ☐ **No** **IF YES, how many?** _____ **Complete below for each organization.**
If additional space is needed, copy and complete this section.

Legal Business Name

Employer Identification Number	Medicare Identification Number	Date Associated FROM ---- TO (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Check if this managing/directing employee has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
☐ Administrative Sanction(s) _____
☐ Program exclusion(s) _____
☐ Suspension of payment(s) _____
☐ Civil monetary penalty(s) _____
☐ Assessment(s) _____
☐ Program Debarment(s) _____

2. Health Care Related:
☐ Criminal fine(s) _____
☐ Restitution order(s) _____
☐ Pending civil judgment(s) _____
☐ Pending criminal judgment(s) _____
☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this managing/directing employee have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

F. Have civil monetary penalties ever been levied against this managing/directing employee by the Medicare/Medicaid program or any Federal agency or program? ☐ **Yes** ☐ **No**
IF YES, has penalty been paid? ☐ **Yes** ☐ **No**

Date(s) of Penalty (MM/DD/YYYY)

14. Parent/Joint Venture Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Check if this entity is a subsidiary company or joint venture. ☐ **Subsidiary Company** ☐ **Joint Venture**

Complete the information below about the PARENT company or JOINT venture.

Attach a copy of parent company's or other owner's IRS Form CP 575 pertaining to this DMEPOS supplier/provider/business/entity.

Legal Business Name		
"Doing Business As" Name		Effective Date of Affiliation (MM/DD/YYYY)
Employer Identification Number	Medicare Identification Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address

15. Chain Organization Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Does the applicant need to register a chain action? (see list below) ☐ **Yes** ☐ **No**

If Yes, check the appropriate action:
☐ Applicant in chain for first time
☐ Applicant dropped out of all chains
☐ Applicant in a different chain since last report
☐ Applicant in same chain under new chain name

Complete the following information about the chain Home Office:

Name of Home Office					
Name of Home Office Administrator or CEO:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title of Home Office Administrator or CEO:					
Home Office Business Street Address Line 1					
Business Street Address Line 2					
City		State		ZIP Code + 4	
Telephone Number ( )		Fax Number ( )		E-mail Address	
Home Office Employer Identification Number		Home Office Medicare Identification Number (if applicable)		Home Office Medicaid Identification Number and State (if applicable)	
Chain Number	Name of Home Office Durable Medical Equipment Regional Carrier				

Applicant's Affiliation to Chain:
☐ Joint Venture/Partnership ☐ Managed/Related ☐ Leased ☐ Other (specify) _____
☐ Operated/Related ☐ Wholly Owned ☐ Subsidiary

16. Contractor/Vendor Information

Check here ☐ **only if this entire section does not apply to the applicant.**

Check here ☐ **if deleting (no longer using) this contractor/vendor.**

How many contractors/vendors does the applicant use? _____

For each contractor/vendor, copy and complete this section.

A. If the applicant contracts for durable medical equipment, prosthetics, orthotics, and/or supplies for which the cost or value is $10,000 or more in a 12-month period, complete the following information for each contractor/vendor with whom applicant has a contract. Submit copy(s) of contract(s) with this application.

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number	Employer Identification Number	Medicare Identification Number (if applicable)

Legal Business Name

Doing Business As Name

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4

Telephone Number ( )	Fax Number ( )	E-mail Address

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)

Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

B. Check if this contractor/vendor has ever had any of the following adverse legal actions imposed by the Medicare, Medicaid, or any other federal agency or program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copy of adverse legal action notification.

1.
- ☐ Administrative Sanction(s) _____
- ☐ Program exclusion(s) _____
- ☐ Suspension of payment(s) _____
- ☐ Civil monetary penalty(s) _____
- ☐ Assessment(s) _____
- ☐ Program Debarment(s) _____

2. Health Care Related:
- ☐ Criminal fine(s) _____
- ☐ Restitution order(s) _____
- ☐ Pending civil judgment(s) _____
- ☐ Pending criminal judgment(s) _____
- ☐ Judgment(s) pending under the False Claims Act _____

3. ☐ None of these

4. Does this contractor/vendor have any outstanding criminal fines? ☐ Yes ☐ No restitution orders? ☐ Yes ☐ No

17. Reassignment of Benefits Statement (Business Organizations and Groups Only)

Check here ☐ **only if this entire section does not apply to the applicant.**

Medicare law prohibits payment for services to entities other than the provider/supplier who provided the services unless the provider/supplier specifically authorizes another entity (employer, facility, health care delivery system, or agent) to bill for its services, per Federal Regulation 42 CFR 424.80. This Reassignment of Benefits Statement, authorizes the DMEPOS supplier identified in Section 1 to receive Medicare payments on your behalf. Your contract with this DMEPOS supplier must be in compliance with HCFA regulations. The Reassignment of Benefits Statement must be signed by all provider/suppliers who allow this applicant to receive payment for their services.

I acknowledge that, under the terms of my employment or contract, _____

(Legal Business Name of Applicant)

is entitled to claim or receive any fees or charges for my services.

Legal Business Name of Reassignee			Reassignee's Medicare Identification Number		
Name of Authorized Representative for the Reassignee (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Signature of Authorized Representative for the Reassignee (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY)

18. Pharmacist-In-Charge

Check here ☐ only if this entire section does not apply to the applicant.

Check here ☐ if deleting this Pharmacist.

If checked, copy and complete this section identifying new Pharmacist-In-Charge, as applicable.

If pharmacy, name of Pharmacist-In-Charge:

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Mailing Address of Pharmacist Line 1

Mailing Address of Pharmacist Line 2

City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address
Social Security Number	Employer Identification Number (if applicable)	Medicare Identification Number (if applicable)
Pharmacist License Number(s) AND State(s) Licensed In	License(s) Issue Date --- Expiration Date (MM/DD/YYYY)	DEA Number

Note: Pharmacist-In-Charge must sign this application in addition to applicant.

19. Billing Agency/Management Service Organization Address

Check here ☐ only if this entire section does not apply to the applicant.

Complete this section if applicant will be using a billing agency or management service organization.

Applicant MUST submit a copy of the applicant's current signed billing agreement/contract with this application.

Name of Billing Agency/Management Service Organization				Employer Identification Number	
Agency/Organization Contact Person Name:	First	Middle	Last	Jr., Sr., etc.	Title

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
Telephone Number ( )	Fax Number ( )	E-mail Address

20. Surety Bond Information

Name of Surety Bond Company

Agent's Name:	First	Middle	Last	Jr., Sr., etc.
Telephone Number ( )			Fax Number ( )	

Amount of Surety Bond $	Effective Date of Surety Bond (MM/DD/YYYY)	Annual Renewal Date of Surety Bond (MM/DD/YYYY)

21. Standards Certification Statement

I certify that I have read, understand, meet, and will continue to meet all supplier standards as outlined in 42 CFR § 424.57. The supplier standards are available through the Medicare Contractor.

Applicant Name: (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Applicant Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

for groups and organizations:

Authorized Representative Name: (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Telephone Number ( )	Date (MM/DD/YYYY)	

Pharmacist-In-Charge (if applicable):

Pharmacist-In-Charge Name: (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Pharmacist-In-Charge Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571. Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program."

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:
a.) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus 3 times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency. . .
a claim. . .that the Secretary determines is for a medical or other item or service that the person knows or should know:
a.) was not provided as claimed; and/or
b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.

22. Certification Statement

I, the undersigned, certify to the following:

1.) **I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare or other federal health care program contractor of this fact immediately.**

2.) **I authorize the Medicare or other federal health care program contractor to verify the information contained herein. I agree to notify the Medicare or other federal health care program contractor of any changes in this form within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.**

3.) **I have read and understand the Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application, as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.**

4.) **I am familiar with and agree to abide by the Medicare or other federal health care program laws, regulations and program instructions that apply to my provider/supplier type. The Medicare laws, regulations and instructions are available through the Medicare Contractor. I understand that payment of a claim by Medicare or other federal health care programs is conditioned on the claim and the underlying transaction complying with such laws, regulations and program instructions (including the anti-kickback statute and the Stark law), and on a provider/supplier being in compliance with any applicable conditions of participation in any federal health care program.**

5.) **Neither I, as an individual practitioner-nor any owner, director, officer, or employee of the company or other organization on whose behalf I am signing this certification statement, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under the Medicare or Medicaid program or debarred, suspended or excluded under any other Federal agency or program, or otherwise is prohibited from providing services to Medicare or other federal health care program beneficiaries.**

6.) **I agree that any existing or future overpayment to me by the Medicare or other federal health care program(s) may be recouped by Medicare or the other federal health care program(s) through withholding future payments.**

7.) **I understand that only the Medicare or other federal health care program(s) billing number for the provider/supplier who performed the service or to whom benefits were reassigned under current Medicare or other federal health care program(s) regulations may be used when billing Medicare or other federal health care program(s) for services.**

8.) **I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicare or other federal health care program(s) to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of Medicare or other federal health care program(s) billing number(s), fines, penalties, damages, and/or imprisonment under Federal law.**

9.) **I will not knowingly present or cause to be presented a false or fraudulent claim for payment by the Medicare or other federal health care programs, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.**

10.) **I further certify that I am the individual practitioner who is applying for the billing number, or in the case of a business organization, I am an officer, chief executive officer, or general partner of the business organization that is applying for the Medicare or other federal health care program(s) billing number.**

Applicant Name: (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Applicant Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

FOR GROUPS AND ORGANIZATIONS: (Please list all "Authorized Representatives" for this group/organization)

Check here ☐ if deleting this representative from this entity.

Authorized Representative Name: (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title/Position	Social Security Number	Medicare Identification Number (if applicable)		
Authorized Representative Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

Check here ☐ if deleting this representative from this entity.

Authorized Representative Name: (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title/Position	Social Security Number	Medicare Identification Number (if applicable)		
Authorized Representative Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

PHARMACIST-IN-CHARGE (if applicable):

Pharmacist-In-Charge Name: (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Pharmacist-In-Charge Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	